| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 152028 | A. BUILDING 00<br>B. WING | 09/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VIBRA HOSPITAL OF NORTHWESTERN INDIANA | 9509 GEORGIA ST<br>CROWN POINT, IN46307 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| S0000 | This visit was for a standard licensure survey.<br><br>Facility Number: 012131<br><br>Survey Date: 09/27-28/2011<br><br>Surveyors:<br>ReBecca Lair, LCSW<br>Medical Surveyor<br><br>Jacqueline Brown, RN<br>Public Health Nurse Surveyor<br><br>Lynnette Smith<br>Laboratorian/Medical Surveyor<br><br>QA: claughlin 10/17/11 | S0000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 152028 | A. BUILDING 00<br>B. WING | 09/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VIBRA HOSPITAL OF NORTHWESTERN INDIANA | 9509 GEORGIA ST<br>CROWN POINT, IN46307 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| S0362 | 410 IAC 15-1.4-1(d)(6)(A)(B)(C)(D)(E)(F)<br><br>(d) The governing board is responsible for assuring that quality patient care is provided. In accordance with hospital policy, the governing board shall do the following:<br><br>6) Ensure that the hospital does the following:<br><br>(A) Establish written protocols to identify potential organ and tissue donors.<br>(B) Has written policies and procedures for the facilitation of organ and tissue donations, including procurement.<br>(C) Inform families or authorized persons of potential organ and tissue donors of the option of donation on admission or at the time of death of a potential donor.<br>(D) Use discretion and sensitivity in contacts with potential organ donor families.<br>(E) Notify the appropriate procurement organization of potential organ donors.<br>(F) Establish membership in the organ procurement and transplantation network if the hospital performs transplants. | | | |
| | Based on document review and staff interview, the governing board failed to ensure forms for identifying potential organ and tissue donors were completed accurately for 3 of 3 (N10, N11 and N13) closed patient medical records reviewed | S0362 | Inservice by Regional Gift of Hope Coordinator provided to Director of Quality on 10/13/11. This included guidelines on completing the form and review of the required reporting requirements and monthly audits. Director of Quality and Chief | 11/21/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 152028 | A. BUILDING 00<br>B. WING | 09/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VIBRA HOSPITAL OF NORTHWESTERN INDIANA | 9509 GEORGIA ST<br>CROWN POINT, IN46307 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | and failed to notify the appropriate organ procurement organization, per contract, of all hospital deaths.<br><br>Findings:<br>1. Review of closed patient medical records at 12:20 PM on 9/27/11, indicated patient:<br>a. N10 expired on 4/7/11 and the form titled, "To be Completed for Every Imminent Death and Expiration":<br>A. lacked a date and time of authentication of the Supervisor in the Outcome section.<br>B. had who was contacted from the Gift of Hope and the name of the family/consent giver in section A. "Patient IS a candidate for...[organ and/or tissue procurement]" when the checkbox in section B. "Patient is NOT a candidate for organ, tissue or cornea donation" was marked.<br>C. section B. was also filled out with who was contacted from the Gift of Hope.<br>b. N11 expired on 4/13/11 and the form titled, "To be Completed for Every Imminent Death and Expiration":<br>A. lacked what the outcome was; Supervisor authentication; and a date and time of authentication of the Supervisor in the Outcome section.<br>B. had who was contacted from the Gift of Hope and the name of the family/consent giver in section A. "Patient | | Clinical Officer provided 1:1 training for nursing staff regarding proper completion of the Gift of Hope form and required timelines for notification. 100% death review audit to ensure compliance and proper documentation. Audit results to be reported to the Quality Committee for tracking, analyzing and trending and quarterly to the Medical Executive Committee and the Governing Board. Responsible Party is the Director of Quality. Completion date is November 21, 2011. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 152028 | A. BUILDING 00<br>B. WING | 09/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VIBRA HOSPITAL OF NORTHWESTERN INDIANA | 9509 GEORGIA ST<br>CROWN POINT, IN46307 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | IS a candidate for...[organ and/or tissue procurement]" when the checkbox in section B. "Patient is NOT a candidate for organ, tissue or cornea donation" was marked.<br>C. section B. was also filled out with who was contacted from the Gift of Hope.<br>c. N13 expired on 6/26/11 and the form titled, "To be Completed for Every Imminent Death and Expiration":<br>A. lacked what the outcome was; Supervisor authentication; and a date and time of authentication of the Supervisor in the Outcome section.<br>B. had who was contacted from the Gift of Hope in section A. "Patient IS a candidate for...[organ and/or tissue procurement]" when the checkbox in section B. "Patient is NOT a candidate for organ, tissue or cornea donation" was marked.<br>C. section B. was also filled out with who was contacted from the Gift of Hope.<br><br>2. Personnel P10 was interviewed on 9/28/11 at 9:07 AM and confirmed the forms for determination of organ and tissue procurement were not completed accurately as described for the above-mentioned patients who expired.<br><br>3. Review of the contract between the hospital and the Gift of Hope Organ & Tissue Donor Network, indicated the | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 152028 | A. BUILDING 00<br>B. WING | 09/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VIBRA HOSPITAL OF NORTHWESTERN INDIANA | 9509 GEORGIA ST<br>CROWN POINT, IN46307 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | hospital shall provide "All notification of death or imminent death...".<br><br>4. Review of Donation Activity Report Scorecard for the year 2010 indicated 1 death occurred in December 2010, however, no deaths were reported for December.<br><br>3. Interview with Employee #A3 on September 28, 2011 at 2pm, at which time review of the Gift of Hope contract documentation and the December 2010 data verified the information. | | | |
| S0556 | 410 IAC 15-1.5-2(b)<br><br>(b) There shall be an active, effective, and written hospital-wide infection control program. Included in this program shall be system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers.<br>Based on policy and procedure review, document review, and staff interview, the facility failed to implement its hospital-wide infection control program per policy and procedure related to screening for immunization status and/or | S0556 | All new employees are obtaining a post-offer/pre-employment history and physical including screening of immunization status and/or history of such.<br>The Employee Health Coordinator is responsible for reviewing the results prior to | 11/21/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 152028 | A. BUILDING 00<br>B. WING | 09/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VIBRA HOSPITAL OF NORTHWESTERN INDIANA | 9509 GEORGIA ST<br>CROWN POINT, IN46307 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | history for 4 of 9 (P2, P6, P8 and P9) personnel health records reviewed.<br><br>Findings:<br>1. Policy titled, "Employee Health Profile" reviewed at 10:00 AM on 9/28/11, indicated:<br>a. on pg. 1, under Procedures section, point 7., "Employee Health Profile addresses TB (tuberculosis) testing and/or screening. Varicella history, Hepatitis B vaccine history, and immunization histories and complies with all applicable local, state and federal regulatory agencies."<br><br>2. Review of personnel health records at 8:30 AM on 9/28/11, indicated:<br>a. Personnel P2, P8, and P9 lacked documentation of immunization status and/or history Varicella. Personnel P2 and P9 had a Health History Questionnaire and/or self-attestation statement that they had the chickenpox and was signed only by the employee, not a physician.<br>b. Personnel P8 lacked documentation of immunization status and/or history for Rubeola.<br>c. Personnel P6 lacked documentation of immunization status and/or history for Rubella.<br><br>3. Personnel P13 was interviewed on 9/28/11 at 10:06 AM, and confirmed | | employment and ensuring the immunization status and/or history is documented. Current employee files are being reviewed to ensure immunization status and/or history is documented. Those non-compliant will be directed to an occupational health center to obtain titers ora verified physician history of status. The Responsible Party is the Infection Control Coordinator. Completion Date November 21, 2011. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 152028 | A. BUILDING 00<br>B. WING | 09/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VIBRA HOSPITAL OF NORTHWESTERN INDIANA | 9509 GEORGIA ST<br>CROWN POINT, IN46307 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | documentation of the immunization status and/or history was lacking as described for the above-mentioned personnel. | | | |
| S0952 | 410 IAC 15-1.5-6(d)<br><br>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6).<br>Based on review of blood administration policies and procedures, patient records, and staff interview, the hospital failed to ensure blood transfusions were administered in accordance with approved policies and procedures for 10 of 10 patient records reviewed.<br><br>Findings included:<br><br>1. Review of blood administration polices and procedures on 9-27-11 between 12:00 PM and 2:20 PM revealed a policy / procedure titled: "Blood Product Administration", policy # "PC NUR 070", last revised on "10.25.10", | S0952 | The Blood Product Administration Policy has been revised to address vital sign documentation and timeliness in accordance with state law and medical staff policies and procedures and will be presented at the Medical Executive Committee followed by the Governing Board. Traning of staff occurred 1:1 beginning October 8 and was reinforced ongoing and presented at two staff meetings in October. The staff nurse notifies the Director of Quality or designee when a blood transfusion is ordered and the above information is reviewed and subsequently audited by the Director of Quality for compliance, tracking and trending. The Chief | 11/21/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 152028 | A. BUILDING 00<br>B. WING | 09/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VIBRA HOSPITAL OF NORTHWESTERN INDIANA | 9509 GEORGIA ST<br>CROWN POINT, IN46307 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | which read:<br>a. "Prior to obtaining blood from Blood Bank assess patient and obtain pre-transfusion vital signs. Vital signs must be taken within 30 minutes of the start of the transfusion."<br>b. "Document patient vital signs (minimally-temperature, pulse, respirations, and blood pressure)...15 minutes after start of transfusion...45 minutes after start of transfusion...2 hours after start of transfusion...3 hours after start of transfusion...one hour post transfusion completion..."<br>c. "Blood transfusions are completed within four hours of blood product removal from the Blood Bank."<br><br>2. Review of patient records on 9-28-11 between 10:00 AM and 1:00 PM revealed the following:<br>a. Patient #L1 was admitted on 5-28-11 and discharged on 6-25-11. The patient received 2 units of leukoreduced packed red blood cells (LR PRBC) and 2 units of fresh frozen plasma (FFP). The first unit of LR PRBC's was initiated on 6-4-11 at "2145". Vitals signs were not documented 45 minutes after the start of the transfusion, as required by approved policies and procedures. The second unit of LR PRBC's was issued from the blood bank on 6-4-11 at "2115 PM" and the transfusion started at "11:30 PM", 2 hours | | Clinical Officer and Director of Quality are responsible for audit of the blood transfusions and compliance with policy and procedure of blood transfusions. Blood product administration documentation will be reported to Quality monthly, Medical Executive Committee quarterly followed by the Governing Board. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 152028 | A. BUILDING 00<br>B. WING | 09/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VIBRA HOSPITAL OF NORTHWESTERN INDIANA | 9509 GEORGIA ST<br>CROWN POINT, IN46307 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | and 15 minutes after it was removed from the blood bank. Fifteen minute vital signs were taken at "2340", 10 minutes after the blood was initiated. Vital signs were not documented 45 minutes, one hour, and two hours after the start of the transfusion, as required by approved policies and procedures. The transfusion was completed on 6-5-11 at "0200", 4 hours and 45 minutes after the blood was removed from the blood bank. One hour post transfusion vital signs were taken at 4:00 AM, two hours after the transfusion was completed. The first unit of FFP was issued on 6-13-11 at "2250" and the transfusion initiated at "2230", 40 minutes after the FFP was removed from the blood bank. The second unit of FFP was issued on 6-13-11 at "2250" and the transfusion initiated at "0016" on 6-14-11, 1 hour and 26 minutes after the unit was removed from the blood bank. Vital signs were not documented 45 minutes after the start of the transfusion, as required by approved policies and procedures. The transfusion was completed at "0105" and one hour post transfusion vital signs were taken at 4:00 AM on 6-14-11, 2 hours and 55 minutes after the transfusion was completed.<br>b. Patient #L2 was admitted on 6-9-11 and discharged on 7-1-11. The patient received 2 units of LR PRBC's. The first transfusion of LR PRBC's was initiated on | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 152028 | A. BUILDING 00<br>B. WING | 09/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VIBRA HOSPITAL OF NORTHWESTERN INDIANA | 9509 GEORGIA ST<br>CROWN POINT, IN46307 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | 6-24-11 at "0920". Pre-transfusion vital signs were taken at "0835", 45 minutes prior to the start of the transfusion. Vital signs were not documented 45 minutes and one hour after the start of the transfusion, as required by approved policies and procedures. The second unit of LR PRBC's was issued from the blood bank at "8:50 AM", and the transfusion initiated at "1015", 1 hour and 25 minutes after the blood was removed from the blood bank.<br>c. Patient #L3 was admitted on 3-25-11 and discharged on 5-6-11. The patient received 3 units of LR PRBC's and one unit of FFP. The first unit of LR PRBC's was initiated on 4-5-11 at "2245" and completed on 4-6-11 at "0200". Vital signs were not documented 45 minutes, one hour, 2 hours, and 3 hours after the transfusion was started, as required by approved policies and procedures. One hour post transfusion vital signs were taken at 4:00 AM, 2 hours after the transfusion was completed. The second unit of LR PRBC's was issued from the blood bank on 4-6-11 at "1224". The time the transfusion was initiated was not documented. It was unable to be determined if the transfusion was initiated within 30 minutes of the time of issue, and whether or not the 15 minute and subsequent vitals signs were taken in the timeframe required by approved policies | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 152028 | A. BUILDING 00<br>B. WING | 09/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VIBRA HOSPITAL OF NORTHWESTERN INDIANA | 9509 GEORGIA ST<br>CROWN POINT, IN46307 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | and procedures. The transfusion was completed at "3:00 PM". The third unit of LR PRBC's was issued from the blood bank on 4-5-11 at "2225" and the transfusion initiated on 4-6-11 at "0255", 4 hours and 30 minutes after the blood was removed from the blood bank. Vital signs were not documented 45 minutes and 2 hours after the start of the transfusion, as required by approved policies and procedures. The transfusion was completed at "0535", 6 hours and 10 minutes after the unit was removed from the blood bank. One hour post transfusion vital signs were not documented, as required by approved policies and procedures. The unit of FFP was issued from the blood bank on 4-6-11 at "0550" and the transfusion was initiated at "0620". Pre-transfusion vital signs were taken at "0535", 45 minutes before the transfusion was initiated. Vital signs were not documented 45 minutes and one hour after the transfusion was initiated, as required by approved policies and procedures. One hour post transfusion vital signs were documented at 9:00 AM, one hour and 15 minutes after the transfusion was completed.<br>d. Patient #L4 was admitted on 7-22-11 and discharged on 8-12-11. The patient received 2 units of LR PRBC's. The second unit of LR PRBC's was issued from the blood bank on 8-9-11 at "1:45 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 152028 | A. BUILDING 00<br>B. WING | 09/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VIBRA HOSPITAL OF NORTHWESTERN INDIANA | 9509 GEORGIA ST<br>CROWN POINT, IN46307 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | PM" and the transfusion initiated at "1445", one hour after it was removed from the blood bank. The unit was completed at "1515" and the one hour post transfusion vital signs taken at "1600", 45 minutes afte the transfusion was completed.<br>e. Patient #L5 was admitted on 4-21-11 and discharged on 6-3-11. The patient received 2 units of LR PRBC's. The first unit was initiated on 4-23-11 at "4:15 PM". Vital signs were not documented 45 minutes, one hour, 2 hours, and 3 hours after the transfusion was started, as required by approved policies and procedures. The transfusion was completed at "8:00 PM", 4 hours and 11 minutes afte the blood was removed from the blood bank. One hour post transfusion vital signs were not documented. The second unit of LR PRBC's was issued from the blood bank on 4-23-11 at "1549" and the transfusion was initiated at "2030", 4 hours and 41 minutes after it was removed from the blood bank. Vital signs were not documented 45 minutes, one hour, and 2 hours after the transfusion was started, as required by approved policies and procedures. The transfusion was completed at "2300", 7 hours and 11 minutes after the blood was removed from the blood bank.<br>f. Patient #L6 was admitted on 5-5-11 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 152028 | A. BUILDING 00<br>B. WING | 09/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VIBRA HOSPITAL OF NORTHWESTERN INDIANA | 9509 GEORGIA ST<br>CROWN POINT, IN46307 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | and discharged on 6-22-11. The patient received 2 units of LR PRBC's. The first unit of LR PRBC's was issued from the blood bank on 5-21-11 at "6:37 PM" and the transfusion initiated at "1940", 1 hours and 3 minutes after the blood was removed from the blood bank. Vital signs were not documented 45 minutes, one hour, 2 hours, and 3 hours after the transfusion was started, as required by approved policies and procedures. Instead, vital signs were documented at "2000" and "2100". The transfusion was completed at "2300", 4 hours and 21 minutes after the blood was removed from the blood bank. The one hour post transfusion pulse, respirations, and blood pressure were not documented, as required by approved policies and procedures. The second unit of LR PRBC's was released from the blood bank on 5-21-11 at "6:37 PM" and the transfusion initiated at "2315", 4 hours and 23 minutes after the blood was removed from the blood bank. The 45 minute pulse, respirations, and blood pressure were not documented. Vital signs were not documented 1 hour and 2 hours after the transfusion was started, as required by approved policies and procedures. The transfusion was completed at "0200", 7 hours and 23 minutes after the blood was released from the blood bank. The one hour post | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 152028 | A. BUILDING 00<br>B. WING | 09/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VIBRA HOSPITAL OF NORTHWESTERN INDIANA | 9509 GEORGIA ST<br>CROWN POINT, IN46307 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | transfusion vital signs were not documented, as required by approved policies and procedures.<br>g. Patient #L7 was admitted on 6-27-11 and discharged on 8-14-11. The patient received 2 units of LR PRBC's. The second unit of LR PRBC's was issued from the blood bank on 7-12-11 at "21:45" and the transfusion initiated on 7-13-11 at "2415", 2 hours and 30 minutes after the blood was removed from the blood bank. Pre-transfusion vital signs were taken at "2415", 2 hours and 30 minutes after the blood was issued from the blood bank, not within 30 minutes prior to release, as required by approved policies and procedures. The transfusion was completed at "0215", 4 hours and 30 minutes after the blood was removed from the blood bank.<br>g. Patient #L8 was admitted on 5-20-11 and discharged on 6-15-11. The patient received 2 units of LR PRBC's. The first transfusion of PR RBC's was initiated on 6-5-11 at "1758". Vital signs were not documented 45 minutes and one hour after the start of the transfusion, as required by approved policies and procedures. The transfusion was completed at "2135". One hour post transfusion vital signs were not documented. The second unit of LR PRBC's was issued from the blood bank on 6-5-11 at "1730" and the transfusion | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 152028 | A. BUILDING 00<br>B. WING | 09/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VIBRA HOSPITAL OF NORTHWESTERN INDIANA | 9509 GEORGIA ST<br>CROWN POINT, IN46307 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | initiated at ""2145", 4 hours and 15 minutes after the blood was removed from the blood bank. Vital signs were not documented 45 minutes, one hour, and 2 hours after the transfusion was started, as required by approved policies and procedures. The transfusion was completed at "0030" 7 hours after the blood was removed from the blood bank. One hour post transfusion vital signs were not documented.<br>h. Patient #L9 was admitted on 8-9-11 and discharged on 8-31-11. The patient received one unit of LR PRBC's. The unit was issued from the blood bank on 8-12-11 at "1700" and the transfusion initiated at "2040", 3 hours and 40 minutes after the blood was removed from the blood bank. Fifteen minute vitals signs were taken at "2100", 20 minutes after the transfusion was initiated. Vital signs were not documented 45 minutes, one hour, 2 hours, and 3 hours after the transfusion was started, as required by approved policies and procedures. The transfusion was completed at "0040", 7 hours and 40 minutes after the unit was removed from the blood bank. One hour post transfusion vital signs were not documented.<br>i. Patient #L10 was admitted on 4-15-11 and discharged on 5-6-11. The patient received 2 units of LR PRBC's. The first unit of LR PRBC's was issued | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 152028 | A. BUILDING 00<br>B. WING | 09/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VIBRA HOSPITAL OF NORTHWESTERN INDIANA | 9509 GEORGIA ST<br>CROWN POINT, IN46307 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | from the blood bank on 4-20-11 at "1123" and the transfusion was initiated at "11:55 AM". Pre-transfusion vital signs were taken at "1100", 55 minutes prior to the start of the transfusion, not within 30 minutes prior to the start of the transfusion, as required by approved policies and procedures. Vital signs were not documented 45 minutes and one hour after the start of the transfusion, as required by approved policies and procedures. The transfusion was completed at "1240" and one hour post transfusion vital signs were not documented. The second unit of LR PRBC's was issued from the blood bank on 4-20-11 at "1123" and the transfusion initiated at "12:40", 1 hour and 17 minutes after the unit was removed from the blood bank. Vital signs were not documented 45 minutes after the start of the transfusion, as required by approved policies and procedures. The transfusion was completed at "1325", and one hour post transfusion vital signs were not documented, as required.<br><br>3. In interview on 9-28-11 between 12:30 PM and 1:00, Staff Member #L23 acknowledged the above findings. | | | |